STEPPING STONE CHIROPRACTIC, PC.

Authorization To Use Or Disclose Protected Health Information

Section A: Patient Giving Consent
Name: _____
Address: _____
City/State: _____
Telephone: _____
Patient #: _____ Social Security #: _____

Section B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

PURPOSE OF CONSENT: By signing this form, you will consent to use and disclosure of your protection health information to carry treatment, payment activities, and healthcare operations.

NOTICE OF PRIVACY PRACTICES: you have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, healthcare operations, the use and disclosure we may make of your information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing.

We reserve the right to change or privacy practice as described in our Notice of Privacy Practices. If we change of privacy practices, we will issue a revises Notice of Privacy practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

RIGHT TO REVOKE: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if your revoke this Consent.

I, _____, have had the full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving consent to your use and disclosure of my protected health information to carry treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If a personal representative on behalf of the patient signs this consent, please complete the following:

Personal Representative's Name: _____

Relationship to the Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.